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ABSTRACT

This review evaluates the efficacy of group treatment for nonoffending caregivers of children who have been sexually abused. A review of the literature focused on the significance of family support and involvement in treatment of sexual abuse, the importance of support groups for parents whose children have been sexually abused, and the efficacy of types of treatment for sexually abused children. The review is divided into three sections: (1) family support; (2) parent support groups; and (3) efficacy of treatment. It describes and evaluates the impact of support and treatment offered to sexually abused children and their nonoffending caregivers. Results of the literature review suggests that parallel group treatment or concurrent treatment of sexually abused children and their nonoffending caregivers are the most effective. What have also been helpful are concurrent parent groups emphasizing psychoeducation and support for the families impacted by abuse. One common finding acknowledged in all articles was the nonoffending caregivers' or mothers' own personal history of sexual abuse. Programs that treat sexually abused children should include treatment and services to the nonoffending parent or caregiver. (Contains 33 references.) (Author/JDM)

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REVIEW OF THE LITERATURE REGARDING NONOFFENDING CAREGIVERS OF SEXUALLY ABUSED CHILDREN: AN EMPHASIS ON PARALLEL GROUP TREATMENT

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REVIEW OF THE LITERATURE REGARDING NONOFFENDING CAREGIVERS OF SEXUALLY ABUSED CHILDREN: AN EMPHASIS ON PARALLEL GROUP TREATMENT

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Kaneeza Lafir

August, 2000

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ABSTRACT

REVIEW OF THE LITERATURE REGARDING NONOFFENDING CAREGIVERS OF SEXUALLY ABUSED CHILDREN: AN EMPHASIS ON PARALLEL GROUP TREATMENT

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Questions regarding childrens' capacity to cope or adapt since the disclosure of their abuse invariably point to the extent of social support the child receives after such disclosure. Given that the family is the first social unit the child encounters and the mother is the first object of socialization, research should focus on the involvement and/or noninvolvement of nonoffending caregivers. The purpose of this literature review is to show the efficacy of parallel group treatment for nonoffending caregivers of sexually abused children who also receive group treatment. Although nonoffending caregiver involvement is strongly urged, empirical evidence about the effects of caregiver participation is very limited. Available data indicate that group treatment of sexually abused children and their nonoffending caregivers is not only the most effective form of treatment from a managed care perspective, but is also the most effective modality of treatment as evidenced in group research. The need for further research is discussed and recommendations are also presented.

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REVIEW OF LITERATURE REGARDING NONOFFENDING CAREGIVERS OF SEXUALLY ABUSED CHILDREN: AN EMPHASIS ON PARALLEL GROUP TREATMENT

Introduction

Sexual abuse of children has risen from obscurity to infamy. It has been a major focus in a global sense for the past two decades. The treatment of sexual abuse has become a significant concern for child therapists who have become increasingly aware of the toll that child sexual abuse takes not only on the child, but also on the family as a unit who have to face the aftermath of the abuse. Some of the questions addressed and explored in treatment efficacy of sexually abused children focus on their coping skills. A review of literature indicates that weekly group therapy for parents is the optimal approach to promote their sense of continuous support. The question of how some children seem to have coped or adapted since their abuse may be answered, in part, by the involvement or noninvolvement of parental/caregiver or familial support. Available literature focuses more on the victims and perpetrators of sexual abuse. The impact of nonoffending caregivers is addressed less often and in less detail.

Research indicates that one fourth of women and one eighth of men will have experienced some type of sexual abuse by the age of 18. The pervasive effect that sexual abuse has on a family cannot be refuted and this has resulted in family treatment being viewed as the treatment of choice by many (Friedrich, 1990.)

Parents and siblings are very clearly affected by the abuse, irrespective of the relational status of the perpetrator (i.e. a family member or not.) The attitude of the family towards the abused child deeply impacts the prognosis of the child. However, involvement of family members in the treatment process has not been easy, especially if the abuse was intrafamilial (Friedrich 1990.) Although the involvement of family in the treatment of extrafamilial abuse is greater, families are still at a loss as to how to deal with the psychological and behavioral issues expressed by some of these children. Most parents seem to be unprepared and uninformed as how to deal with their child's abuse. In many cases this leads to a lack of parental protection and security that is provided under nonabusive circumstances. McFarlane et al. noted that in cases where a very young child is abused, the trauma to the parent is more significant than the trauma to the child (Mc Farlane, et al., 1986).

Mandell and Damon (1989) proposed a parallel group treatment model to treat young victims of sexual abuse. Based on their clinical experience in dealing with sexually abused children, they determined that a structured and directive group treatment can help children to experience "relief, achieve confidence and mastery, and develop age appropriate defenses" (p.3). Regarding the treatment of caregivers, they state that group treatment can offer "nonoffending parents and guardians the opportunity to examine their own feelings and concerns about the sexual molestation, thereby increasing their capacity to understand the effects of this trauma on the development and the functioning of the victims" (p.3).

The treatment of sexual abuse can be viewed from many perspectives. The family systems perspective addresses the all-encompassing effects of child sexual abuse not

only on the sexually abused child, but also on the family as a whole unit by employing family therapy (Mara & Winton, 1990). Friedrich (1990) reiterates the significance of parental support when he states "parental support is critical, outstripping abuse characteristics in predicting at least short-term behavioral reaction to the abuse" (p.28). Most mothers are distressed when abuse is disclosed by their children and the importance of this is seen in the diagnostic formulation of Post Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM III American Psychiatric Association 3rd ed. rev. 1987). PTSD is described as a condition resulting not only from a threat or harm to the self, but also as a result of "…serious threat or harm to one's children" (p. 247). In the past, nonoffending mothers have been perceived as being unsupportive of their children and at least partially to blame for their child's victimization (James & Nasjleti, 1983). This has resulted in the therapeutic needs of nonoffending mothers and caregivers being overlooked. Meiselman (1987) viewed the mother as the "third party in a father-daughter incest relationship" (p.112). This is a strong indicator for the necessity of including mothers when formulating a treatment plan.

A review of the literature indicates that nonoffending caregivers most often reported symptoms of guilt, panic, shock, and the feeling of loss of control. Most parents also reported being frustrated by the perceived intrusive involvement of child protective services, social workers, and the police. Furniss (1991) reported that nonoffending caregivers need a place to process the impact the sexual abuse of their child has had on them. Common parental/caregiver concerns regarding how the abuse may have impacted the child's sense of sexuality, overall development, as well as their

own issues of uncertainty about letting their children see how upset they are can be addressed in a group with members facing similar circumstances.

A literature review indicates that different types of groups have surfaced in the past decade ranging from school settings (DeVoss & Newlon, 1986) and videotaped parent education group programs for abusive parents (Golub, Espinosa, Damon, & Card, 1987) to a parallel group treatment model where issues were addressed in both groups, i.e., by the mothers and their abused children respectively (Damon & Waterman, 1986). DeVoss and Newlon (1986) suggested the establishment of community based programs for families who might not otherwise receive counseling during the crises they often face after disclosure of sexual abuse of their child. The purpose of this literature review is to examine the effectiveness of parallel group treatment of sexually abused children and their nonoffending caregivers.

Review of the Literature

The literature reviewed in this paper focuses on the significance of family support and involvement in the treatment of sexual abuse, the importance of support groups for parents whose children have been sexually abused, and the efficacy of types of treatment for sexually abused children and their families. The literature reviewed in this paper is divided into three sections: a) Family Support, b) Parent Support Groups, and c) Efficacy of Treatment. In these sections the impact of support and treatment offered to sexually abused children and their nonoffending caregivers is described and evaluated.

Family Support

This section reviews the level of involvement and noninvolvement and the impact of familial support in the overall treatment of sexually abused children.

Cohen and Mannarino's Study

Cohen and Mannarino (1998), in their follow-up study of factors that mediate treatment outcome of sexually abused preschool children, indicated the strong impact of parental support on treatment outcome. They hypothesized that parental distress regarding the abuse and lack of parental support of the child would predict poorer outcomes at both follow-up times: six-months (T3) and 12-months (T4). These results were compared to the results obtained prior to treatment (T1) and on completing treatment (T2).

Method. Cohen and Mannarino (1998) defined sexual abuse as sexual exploitation involving physical contact between a child and another person. "Physical contact" included anal, genital, oral, and/or breast contact. To be included in this study, children had to have experienced some form of sexual abuse as defined above within 6 months of referral to the treatment program. A total of 67 subjects whose ages ranged from 2 years 11 months to 7 years 1 month were recruited from a pool of 86 subjects referred for the study. Subjects were referred from regional rape crisis centers, Child Protective Services (CPS), pediatricians, psychologists, community mental health agencies, county and municipal police departments, and the judicial system. The children had to reach a minimal level of symptomatology which the researchers defined as a Weekly Behavior Report (WBR) Total score of > 7 or any sexually inappropriate behavior reported on the Child Sexual Behavior Inventory (CSBI).

Children diagnosed with mental retardation or pervasive developmental disorder were excluded from the study. Also excluded were children displaying psychotic symptoms and/or a serious medical illness. Psychotic disorder or active substance abuse in the parent participating in treatment or the lack of a long-term caretaker to participate in the study were also utilized as exclusionary criteria.

For purposes of evaluation, the sample was classified into two groups: completers and noncompleters. According to the researchers, the three types of noncompleters did not differ from each other with regard to demographics or initial symptomatology. No significant differences were found between noncompleters and completers, except that the noncompleters, on the average, were of a lower socioeconomic status (SES $p < .05$). The mean age of treatment completers was 5.9 years (range 4.2 to 7.11 years); 56% were female and 44% were male. Males did not differ from females with regard to age, placement, race, or SES. They also did not differ with regard to number of times abused, use of force, or identity of perpetrator. Racial composition was 56% Caucasian and 44% African-American. Seventy-six percent of the subjects lived with one (55%) or both (21%) biological parents, 5% lived with adoptive parents, 2% lived with grandparents, 2% lived with other relatives, and 10% lived with a long-term foster parent.

Severity of sexual abuse indicated that 26% were abused once, 33% were abused 2 to 5 times, 14% were abused 6 to 10 times, 23 % were abused more than 10 times, and in 4% of the cases, the number of abuse episodes was not known. Regarding the identity of the perpetrator, 9% were the biological father, 2% the biological mother, 12% the mother's paramour, 7% an uncle, 7% a babysitter, 13% an older

child/adolescent, 16% multiple abusers, and other (40%). Types of abuse experienced included 26% genital fondling only, 9 % vaginal and/or anal intercourse, 19% oral-genital contact, 7 % other/unknown, and 39 % of the subjects experienced more than one type of abuse. Based on the researchers' hypothesis that parental and familial functioning mediated symptom improvement, outcome measures used included child and parental measures. Child measures were used to assess the child's symptoms at different times during the study. Parental measures included those that identified factors that could mediate treatment outcome.

The Child Behavior Checklist (CBCL) was administered to parents and caregivers to assess their child's social competence, behavioral, and adjustment problems. The Child Sexual Behavior Inventory (CSBI) was used to measure sexualized behaviors which ranged from normal behaviors to explicit sexual activity. The Weekly Behavior Report (WBR) was administered to the parents to assess the frequency of 21 specific problematic preschool childhood behaviors over the course of any given week.

Parents also completed the Beck Depression Inventory (BDI), which indicated their own depressive symptoms. They were also administered the Parental Emotional Reaction Questionnaire (PERQ) which was specifically designed to assess parental reaction to their child's sexual abuse. The Parental Support Questionnaire (PSQ), was administered to measure parental support of the sexually abused child and parental attributions about the abuse. The Maternal Social Support Index (MSSI) was administered to the parent or caregiver to assess social support available to mothers of abused children. The Family Adaptability and Cohesion Evaluation Scales-III (FACES-III) were also administered to the parents. These outcome measures were

administered to the parents pre-and post-treatment.

The children completed the Battelle Developmental Inventory, a widely used developmental evaluation instrument which assesses the functioning of children in a variety of domains from 0 to 8 years of age. The Peabody Picture Vocabulary Test–Revised (PPVT-R), a widely used instrument which measures receptive vocabulary in children from 2 ½ years to 18 years, was also administered. Both these instruments were administered only at the beginning of treatment due to their variables being stable over a short period of time (i.e. the 3 months duration of treatment.)

Results. Forty-three sexually abused preschool children and their parents were randomly assigned to one of two types of treatment interventions: a) Cognitive-Behavioral Therapy Adapted for Sexually Abused Preschool (CBT-SAP), and b) Nondirective Supportive Therapy (NST). Treatment consisted of 12 individual sessions for both the child and the parent. They were reevaluated at the completion of treatment and 6 and 12 months after treatment was completed. Provision was also made for the same type of treatment on an as-needed basis if sexually inappropriate behavior occurred during the 12 month period after treatment was completed.

Correlational analyses and stepwise multiple regression analyses were performed on each outcome variable. Mediating factors that reached significance of $p < .01$ were entered as variables to minimize the possibility of type I errors due to the large numbers examined. Cohen & Mannarino (1998) observed that the pre- and posttreatment data of the PERQ strongly supported the involvement of family members as significantly impacting the treatment outcome. This was also evident in the 6 month and 1 year follow-up.

Results of the 6-month follow up indicated that parental emotional support, in terms of the support given to the parents and/or caregiver (MSSI) and to the child by the mother (PSQ: $F = 5.46$, $p < .05$), predicted a more positive treatment outcome. However, there were no significant findings for the CSBI or WBR. The only pretreatment mediating factor that independently predicted outcome at the 6 month follow-up was the Battelle Personal Social Score ($F = 4.45$, $p < .05$). The only posttreatment (T2) mediating factors that significantly predicted outcome at the six-month follow up were the PSQ (T3 WBR – Total: $F = 5.46$, $p < .05$), and the MSSI (T3 CBCL Social Competence scale: $F = 4.65$, $p < .05$).

Results of the 12-month follow-up indicated that group treatment explained the greatest part of the variance for the T4 CSBI (13%), T4 WBR Type (24%) and T4 WBR-Total (28%.) The group that received CBT-SAP predicted a better outcome on all three scales. Overall analyses of data obtained suggested that parental emotional distress regarding the abuse and lack of parental support of the child predicted poorer child outcomes at both follow up points. The researchers observed that the most striking finding was the importance of parental emotional support, both in terms of support given to the mother (MSSI) and to the child by the mother (PSQ.) The MSSI which only predicted social competence at posttreatment (T2) was a strong predictor of outcome at the end of 6 and 12 months along with the PSQ. Parental distress (measured by the PERQ), which was a stronger predictor of outcome at posttreatment, became a less significant predictor of child outcome at the 6 and 12 month follow-up periods.

The researchers did not indicate what criteria they used to establish the two groups (CBT-SAP and NST) and how subjects were assigned to each of these groups.

They also did not address how the emotional distress experienced by the parents or caregivers had diminished, and they did not rule out the impact of confounding variables such as the possibility of getting relief due to legal recourse, the child returning to normal functioning, and the passage of time. They also did not indicate the time lapse between disclosure of abuse and start of treatment. Heightened stress levels experienced by both the child and the caregiver could also have significantly impacted the outcome measures. The researchers did not indicate if any form of intervention such as crisis counseling and participation in support groups had occurred prior to treatment. Premorbid functioning of the abused child and the family were also not reported. The researchers' utilization of the PPVT to predict general intelligence is questionable. The PPVT is a screening instrument for receptive language which indicates exposure to the environment and general information. Clinicians are cautioned against using this test interchangeably with IQ scores and for measuring intellectual levels of functioning, particularly of ethnic minority children (Sattler, 1992).

Bentovim, Boston, and Elburg's Study

Bentovim, Boston, and Elburg, (1987) studied children and families referred to a child sexual abuse treatment project. They reported the family's consensus that the abuse had occurred was an important factor in determining which children could be rehabilitated with both their parents, with their mothers only, or with new families. They also reported that family consensus determined which families could be offered treatment or accepted treatment and whether positive changes had occurred in the family. They described the goals of their project as 1) limiting the physical and emotional damage to the child and improving the child's emotional functioning,

2) ensuring the prevention of further abuse which is initially done by maintaining physical distance between the perpetrator and the child, and 3) making changes in the family structure by working on marital issues, working with parents' groups, and with mothers' groups.

Method. The study involved 274 families who were referred to a hospital-based sexual abuse project between 1981 and mid 1986 by the department of social services. A variety of family structures was reported. There were 39% nuclear families (biological or adopted families and children), 12 % single parents who had been divorced, and 11 % common law families. The degree of stability of family membership was also reported (57% had been together for five years or more and 99% of them had been together for more than 10 years). Ninety-percent of the families were Caucasian.

The group was comprised of 77% girl victims. Among the nonvictim siblings, boys comprised 57% while girls comprised 43%. Children were allocated to groups according to the age of onset of the abuse. The ages of onset reported were: 3-5 years (23%), 6-8 years (24%), under 3 years (5%), and 15 or 16 years (3%). Boys were noted to have been abused over a longer time than girls and they tended to be more severely abused than girls.

Information to assess the effect of intervention was gathered retrospectively for the first half of the cases from case files, structured interviews with community professionals who had worked with the family, and interviews with the professionals who had worked with the families in the hospital department. For the second half of the cases, information was gathered prospectively by means of detailed questionnaires

which were sent out to the referral agencies. Overall data was gathered from 411 abused children and their 362 nonabused siblings from the 274 families referred to the treatment program.

Results. Fifty-five of the 120 families completed a course of family treatment and 40 attended some family treatment sessions which were conducted by social workers or prison officers, occasionally in the prison. Family treatment took place every 4 to 6 weeks over 12 to 15 months. The focus of these meetings (between 5 and 10) was on issues of responsibility for the abuse, the changes needed for families to become protective, and how they could achieve these changes. About half (84) of the 180 victims participated in and completed the children's groups and another 48 attended some of the group meetings. Children under age 10 were in mixed groups of boys and girls for weekly sessions over 6 weeks. Adolescent children were placed in separate groups for boys and girls for 12 to 15 weeks. These groups were structured and focused on helping children understand what had happened to them, how to cope with the resulting trauma, and how to protect themselves.

Eighteen parents (10%) received weekly individual treatment lasting from 3 months to a year. Ten percent of the couples attended parents' groups and 9% attended separate mothers' or fathers' groups. These parents' groups took place parallel to the children's groups that continued for 12 to 15 weeks with some children and parents coming to more than one course of treatment. The focus of the structured parent groups was the personal, marital, and family issues that led to the abuse or failure to protect the children. Family meetings during group work helped to integrate group experiences.

Follow-up studies revealed that there had been an overall improvement in 61% of the victim's circumstances, the situation had not changed for 24%, and that it had actually become worse for 10%. This was further corroborated by the fact that 69% of the children reported no reabuse. Reabuse was reported by 16% of the subjects and reabuse was not clear in 15% of the cases. At the time of referral, less than half of the victims (43%) had accepted that abuse had occurred, but at the time of follow-up 63% accepted that the abuse had occurred. This change could be attributed to the fact that perpetrators and those who disbelieved had left the family house, or it could be an effect of the treatment given to these families. This study also indicated that when there was a consensus in the family that the abuse had occurred, they were more willing to participate in treatment.

While the researchers attempted to include a large sample size, this study did not clearly indicate whether parents who participated were nonoffending caregivers or perpetrators. Data from the childrens' group participation did not indicate the proportion of sexually abused children and their siblings. Results of this study did not clearly delineate whether or not the changes observed were more prominent within the shorter treatment period.

Newberger, Gremy, Waternaux, and Newberger's Study

Newberger, Gremy, Watrenaux, and Newberger (1993) examined the course of mothers' psychological functioning over the year following disclosure of their children's sexual abuse by their children. Newberger et al., also studied the relationship between the mothers' emotional well-being and their children's emotional states. The researchers hypothesized that addressing maternal distress is important to the study and

treatment of child sexual abuse. They stressed the importance of maternal well being as it relates to the positive prognosis of sexually abused children. The children and their mothers were recruited from the Emergency Department of Children's Hospital in Boston and from four prosecutor offices in the greater Boston area. Of the 77 families contacted, 64% agreed to participate in the study. The researchers classified abuse as intrafamilial and extrafamilial. They identified intrafamilial perpetrators to be biological fathers, father figures such as stepfathers or mothers' boyfriends, uncles, cousins, and siblings. They identified extrafamilial perpetrators as individuals who were either known or unknown assailants with whom the child or family had no familial connection. All the measures were read to the subjects to assure that the reading ability of the subjects did not impact the findings.

Method. Forty-six boys (28%) and girls (72%) between the ages of 6 and 12 were included in the study if their sexual abuse had been substantiated by protective services and they had no major physical or mental disability. Forty-two of these children were retained for follow-up to the end of the year. Forty-four mothers and two maternal caregivers (a custodial stepmother and a custodial grandmother) who were comparable in age, gender, race, and socioeconomic status were studied. Mothers were partitioned into clinical and nonclinical groups based on their GSI (General Symptom Index) scores. No correlation was found between ethnicity and social status or between SES and gender or age of the child. Oral-genital contact and vaginal penetration was reported in 76% of the cases. Biological fathers or father-figures (stepfathers or mother's male partners) were identified as perpetrators in 28% of the cases. The initial interviews were conducted within 2 months of sexual abuse disclosure by the child.

The median time from disclosure to the initial interview was 9 weeks.

Interviews were conducted at the time of recruitment into the study, and at 6 months and 12 months following the initial interview. Mothers and children were interviewed separately in their homes by two-woman teams composed of professionals with social work, psychology, or special education backgrounds who were trained to administer the measures used in the study. Victimization information was collected from the mothers using a detailed questionnaire. The children could not be directly questioned due to restrictions imposed by the cooperating attorneys for prosecutory purposes. Maternal symptomatology was assessed with the Brief Symptom Inventory (BSI) which assesses the presence and severity of symptoms. The General Symptom Index (GSI) which is a summary scale that incorporates the number and severity of symptoms reported was also used with the mothers. GSI scales which measured symptom dimensions included Somatization, Obsessive Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Both of these instruments are known to discriminate between clinical and non-clinical samples. Children's symptomatolgy was assessed by the Children's Depression Inventory (CDI) and the Revised Children's Manifest Anxiety Scale (RCMAS), both self-report measures. The Child Behavior Checklist (CBCL), an objective measure of children's behavior, was also used to assess symptomatology.

Results. Seventy-two percent of the mothers from the original cohort were reported to have received at least one type of treatment by a mental health professional. Therapy included individual (24), family (12), group (7), or couple's therapy (7) and 13 received no therapy at all. Mothers who reported more psychological distress on the

first interview were given more therapy over the 1-year period of the study ($r = .36$, $p < .02$).

At the time of the first interview the mothers had reported severe symptoms of emotional distress and over 50% had GSI scores that exceeded one standard deviation above the mean. The mothers scored significantly higher on 7 of the 9 specific symptom subscales, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranaoid Ideation, Psychoticism ($p < .001$). Paired t-tests were used to compare maternal symptomatology at the time of the initial interview with symptomatology at the 12 month follow up. Results indicated a significant improvement between initial GSI scores and GSI scores at the end of 1 year ($t = -3.896$, $p < .001$). A significant decline was indicated especially on Phobic Anxiety ($t = -3.175$, $p < .01$), Obsessive-Compulsive ($t = -2.999$, $p < .01$), Interpersonal Sensitivity ($t = -2.585$, $p < .05$), and Psychoticism ($t = -2.585$, $p < .05$) dimensions. No significant decrease was indicated in the Anxiety scale. Four of the scales, Somatization, Obsessive Compulsive, Interpersonal Sensitivity, and Depression declined to the normal range. Symptom levels on the other scales (Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism) remained significantly higher than the normal range.

Mothers' GSI scores indicated that those who participated in family therapy showed a decline in their symptoms. Their recovery was related both to the number of family therapy sessions ($r = -.35$, $p < .05$) and to the length of time families were in treatment ($r = -.35$, $p < .05$). Mothers' initial GSI scores were also related to the total number of treatment contacts their children received ($r = -.35$, $p < .05$); their children's

treatment was associated with declining maternal GSI scores ($r = -.35$, $p < .05$). Mothers' improvement concurrent with their children's treatment remained significant even when controlled for their own therapy.

Data from the first interview showed significant correlations between the CBCL and GSI scores, and that mothers' reports of their own emotional symptoms were strongly consistent with their reports of their children's emotional states. The study revealed that mothers did suffer extensive and severe emotional distress following the disclosure of sexual abuse. Mother-child agreement on the children's emotional state was assessed and reported to be consistently poor. The researchers suggested that when mothers are stressed, they might also be affected by their emotional pain and have difficulty separating their own feelings from those of their child.

Limitations of the study included questions regarding the validity of self-report measures, the lack of a control group, the lack of standardized instruments to measure the trauma of the caregiver, and maturational effects such as the result of time lapse between disclosure and the beginning of therapy. The researchers did not mention the premorbid level of functioning of the children and their mothers, which could have significantly influenced the responses to the questionnaire. They also did not indicate the experiences these families had when interacting with outside agencies such as the Child Protective Services, a normal procedure when child abuse is reported. In most cases this can be quite harrowing and may have impacted the already existent stress level and to some extent even retraumatized the families. The researchers did not clearly delineate if the parallel treatment was offered. Since the maternal stress reported did not relate to the therapy being received by the mothers, the result indicating the

efficacy of treatment should be viewed with caution.

Corder, Haizlip, and DeBoer's Study

This pilot study conducted by Corder, Haizlip, and DeBoer (1990) focused on the development of defense mechanisms that appeared to be important to the subjects in the mastery of trauma and chronic stress. Two pilot groups attended by sexually abused children and their mothers were studied. The mother's participation in the first group was limited to working on group homework with the child after each session. In the second pilot group, maternal participation was increased by allowing mothers to attend each session and share the activities with their child.

Corder et al., (1990) described the goals of the group as 1) improvement in the ability to cognitively and emotionally master and integrate the trauma through structured group discussions, games, and other activities, 2) improvement of self-esteem by cognitive relabeling, utilizing role plays, chants, cheers, and interaction with other sexually abused children, 3) improvement of problem solving skills by structured learning experiences such as special board games and role-play, 4) improvement in the ability to seek help and support from the environment by learning how and whom to contact about the abuse, and 5) improved understanding of the abuse between mother and child.

Method. Materials for the pilot groups were developed from working with sexually abused children aged 8 and 9 individually and in family groups over a 2 year period. Corder et al., (1990) developed structured group therapy techniques which were designed to foster mastering of skills in sexually abused children. Intellectualization defenses were developed through therapeutic board games, and cathartic exploration of

feelings was facilitated through structured art and storytelling exercises. Cognitive relabeling and self-esteem building were developed through role play, chants, and cheers.

Eight sexually abused 6 to 9-year old girls were the subjects for this study. They were referred from a county department of social services after abuse was initially substantiated and they had received some form of brief intervention. Perpetrators were reported to be family members (stepfather, boyfriend of mother, uncle, and grandfather) who were no longer living in the home of the child. Premorbid functioning of these children was reported to be adequate. The abuse reported was short term and without severe physical violence. Symptoms exhibited by the children ranged from mild to moderate and included bad dreams, mild sleep disturbances, excessive sexual concerns, mild depression, and withdrawal. Children who showed symptoms of psychosis or severe hyperactivity were excluded from the study and referrals were made for intensive individual psychotherapy. Individual and group work with sexually abused children and their families provided the basic materials for this pilot group. The majority of the children were reported to have exhibited a reasonable level of adjustment prior to the abuse.

Results. Group treatment for the mothers varied from reviewing their children's homework in one pilot group to attending each session in a later pilot group. All the mothers were also seen individually for varied lengths of time by social workers as part of the agency's intervention with the family. The groups met for 20 sessions over a 5 month period and the sessions lasted an hour. The first two introductory sessions outlined the goals of the groups. Four informational sessions followed that helped

define the terms and experience of sexual abuse. These sessions were designed to help with the development of intellectualization defenses and the "vocabulary" to describe feelings and experiences related to the abuse. These six initial sessions were followed by five sessions that focused on opportunities for cathartic release and coping with feelings surrounding the abuse. Seven sessions emphasized the development of other mastery techniques like problem solving, building self-esteem, and learning to identify potential support systems to cope with the abuse. The final two sessions focused on closure and termination of the group process. In the first pilot group the mothers' participation was limited to working with the child on homework. In the second pilot group their participation involved attending each group session and sharing their activities with the child. Positive feedback by other group members and the group facilitator was provided to each child at the end of every session to increase self-esteem.

No standardized instruments were used in this pilot study. Data were collected in the form of anecdotal interviews with parents, teachers, and social workers involved with the children. A decrease in symptoms was seen in all subjects. Fewer incidences of sleep disturbances and increased compliance was reported at home and school. All parents indicated that their children were more verbal about their abuse experiences and seemed comfortable in expressing their feelings related to the abuse. Anecdotal material and feedback from teachers, parents, and social workers reflected positive results from the group experience and lowered levels of anxiety for the children. Group members also indicated increased intellectual understanding of the experience of abuse and the development of some skills for avoiding abuse in the future.

The limitations of this study are the same as encountered in most other sexual abuse groups: the lack of standardized measures, concerns regarding validity of the self-report measures, and the small sample size. The role of the mothers in this study was not very clear. The researchers were not very clear about what was meant when they "allowed weekly participation in group sessions" for the mothers. They did not clearly delineate if the changes observed were directly impacted by maternal participation.

Pithers, Gray, Busconi, and Houchens Study

Pithers, Gray, Busconi, and Houchens (1998) focused on the psychological characteristics of parents of children with sexual behavior problems. They identified a behavior as problematic if it was repetitive and unresponsive to adult intervention and supervision. The behavior was identified as pervasive when it occurred across time and situations. These behaviors were defined as equivalent to a criminal violation if performed by an adult.

In a previous study with children who had engaged in sexual misconduct conducted by the same researchers (Gray, Busconi, Houchens, & Pithers, 1997, as cited in Pithers, Gray, Busconi, & Houchens, 1998) indicated that 95 % of these children had been sexually abused, 48% were physically abused, and a third of them had been emotionally abused. They found that most of them had been victims of multiple forms of abuse with the most frequent being a combination of physical and sexual abuse. Pithers et al., (1998) observed that parents and families of children with sexual behavior problems were faced with severe difficulties, particularly with high stress levels and a

sense of isolation. Their study indicated that effective treatment of children with sexual problems must encompass treatment of their families.

Method. Adults who were the primary caregivers of sexually misbehaving children between the ages of 6 and 12 years were the subjects of this study. The caregivers' ages ranged from 22 to 51 years with a mean of 32.3. Their years of education ranged from 7 to 18 years with an overall mean of 12.0 years. Most subjects had completed high school (72 %). More than half (51.4%) lived with a partner, 38.9% of this cohort were married, and 12.5% had divorced and remarried. The sample was comprised of 75% biological parents and 25% foster parents. The foster families reported a significantly higher income than the biological families ($p < .0001$). A majority of the children (53%) had witnessed familial violence between the parents with whom they were living. More of the children living with their biological parents had witnessed violence between their parents (70.2%) than had children living with foster parents (20%).

Two-hour interviews were conducted with the children, and their caregivers were given self-report measures at the time of intake. Caregivers were administered the Family Environment Scale (FES), which assessed three main domains: Relationship (cohesion, expressiveness, and conflict subscales), Personal Growth (independence, achievement, intellectual-cultural orientation, moral-religious emphasis subscales), and System Maintenance (organization and control subscales). The Brief Symptom Inventory (BSI) was also administered to the parents to assess 9 primary dimensions: hostility, anxiety, depression, phobic anxiety, somatization, obsessive-compulsive, interpersonal sensitivity, paranoid ideation, and psychoticism. Three global indices of

psychopatholgy were generated: the Global Symptom Index (GSI), the Positive Symptom Total (PST) and the Positive Symptom Distress Index (PSDI). The Parenting Stress Index (PSI), was administered to measure the level of distress in the parent-child relationship, assessing two domains: Child Characteristics (Child Adaptability, Acceptability of Child to the Parent, Child Mood, Child Demandingness, Distractible, Hyperactive, and Child Reinforces Parent subscales), and Parent characteristics (Depression, Attachment, Restrictions Imposed By Role, Sense of Competence, Social Isolation, Relationship with Spouse and Health subscales).

Elevations of the Child Characteristics scores indicated that the child's characteristics were the major source of stress in the parent-child relationship. High Total scores indicated a need for referral to a healthcare professional. The State-Trait Anxiety Expression Scale (STAXI) was administered to measure the intensity of anger and to determine if the disposition to anger was more of a personality trait (reaction and temperament subscales) than an emotional reaction. Anger-in, anger-out, and anger-from subscales indicated how frequently anger was expressed. The State-Trait Anxiety Inventory (STAI) evaluated state anxiety (intensity of current anxiety) and trait anxiety (the degree to which one typically feels anxious.) The subjects were also administered the Social Provision Scale (SPS) to identify if their current social relationships provided guidance, reliable alliance, reassurance of worth, social integration, attachment, and the opportunity to provide nurturance.

Results. Pre-treatment assessment was completed by female caregivers of 72 children with sexual behavior problems. Only four of the caregivers (5.5%) were male. The researchers promoted group treatment as a method of forming and fostering a

support network for caregivers of children with sexual behavior problems. Treatment was for a period of 32 weeks and a 2-year follow-up period.

Data obtained indicated that caregivers or biological parents manifested higher levels of life stress than foster parents. Data also indicated that all the mean subscale scores on the FES were within one standard deviation and in the normal range. The families' two highest scales on the FES were Conflict and Control followed by Organization. Multiple analysis of variance (MANOVA) statistics for a comparison of FES subscale scores for biological families and foster families found a statistically significant difference ($p < .000$). Univariate analysis of variance (ANOVA) indicated that foster parents differed significantly from biological parents on 6 of the 10 FES subscales. On the relationship dimension, significant differences were found between Cohesion ($p < .0002$), Expressiveness ($p < .05$), and Conflict ($p < .0001$) subscales. Foster families were reported to have received higher scores on Cohesion (Foster $M = 7.9$, $SD = 1.79$, Biological $M = 5.3$, $SD = 1.27$) and Expressiveness (Foster $M = 7.9$, $SD = 1.89$, Biological $M = 5.3$, $SD = 1.27$) subscales than biological families. On the Conflict subscale, biological families received a higher mean score than foster families (Biological $M = 4.8$, $SD = 1.84$; Foster $M = 2.9$; $SD = 1.66$). On the Personal Growth Dimension, foster families had significantly higher scores than biological families on two of the five subscales: Intellectual Cultural Orientation ($p < .0004$) and Active Recreational Orientation ($p < .0007$). These results classified biological and foster families into two different subtypes. Foster families met the criteria for Relationship Oriented and Support Oriented families where a commitment to help each other is demonstrated. Biological families remained in the System-Maintenance and

Disorganized subtype with interaction amongst family members being imbued with conflict, and the personal resources of the family member being allocated to maintaining the integrity of the family.

The BSI indicated that the caregivers' Global Severity Index (GSI) grand mean score (.77), which was equivalent to a T score of 63, surpassed the threshold score for psychological distress and diagnosis. Two subscales of the BSI, Psychoticism and Paranoid Ideation also reached a T score of 63 which indicated that caregivers were stressed. A MANOVA found a significant difference across the BSI subscale scores of foster parents and biological parents ($p < .04$). Univariate ANOVA found that foster parents and biological parents differed significantly on all of the BSI subscales.

Data from the PSI indicated that the grand mean Total score for caregivers was in the 91st percentile ($M = 270.1$, $SD = 48.34$), placing them outside the normal range and recommending them for professional help. A significant difference was noted between biological and foster parents ($p < .05$) with the foster parents receiving a lower mean score. A significant difference ($p < .000$) was observed between foster parents and biological parents across the subscales that comprised the PSI Parent Characteristics with biological parents receiving significantly higher scores on six out of the seven subscales and the summary scale as indicated by MANOVA. Caregiver data on the Social Provision Scale (SPS) reported a decline within one standard deviation of the normative mean. Comparing the scores of biological parents and foster parents, biological parents experienced significantly less social support than foster parents ($p < .01$).

MANOVA on the State-Trait Anger Expression Scale (STAXI) indicated significant differences across subscales between biological and foster parents ($p < .01$). Univariate ANOVA indicated significant differences between two subscales, Anger-In ($p < .02$) and Anger Expression ($p < .03$), with the scores being greater for biological parents. Compared to foster parents, biological parents reported significantly higher levels of both State Anxiety ($p < .000$) and Trait Anxiety ($p < .000$). The researchers reported a high incidence of domestic violence and that parents of sexually aggressive children found both the parenting tasks and the parent-child relationship quite difficult. The researchers suggested that given the high level of psychological distress, familial chaos, and impaired parent-child relationships, these parents might need greater than average levels of social support to function effectively. The results of this study strongly indicated the need to conduct group treatment for parents of children with sexual behavior problems.

A major limitation of this study was the reliance on self-reports. Respondents' defensiveness about admitting personal and parenting problems and denying excessive anger or anxiety may have confounded the results obtained in this study. Other results, such as the stress faced by the parents in this study, may not have been totally associated with their children's behavior. The researchers did not indicate what kind of therapy was offered to the parents either prior, during, or after the study.

Deblinger, Hathaway, Lippmann, and Steer's Study

Deblinger, Hathaway, Lippmann, and Steer (1993) conducted a study which compared the psychosocial characteristics and correlates of symptom distress of 99

nonoffending mothers of sexually abused children. Based on the perpetrator's relationship to the mother, mothers were placed in three groups: mothers of the children abused by their fathers or father-figures (36), mothers of children abused by other relatives (30), and mothers whose children were abused by non-relatives (33). Contact sexual abuse was defined as "touching, with or without force, perpetrated by anyone at least 5 years older than the victim" (p.158).

Method. Nonoffending mothers of suspected victims of sexual abuse were invited to participate in a study at the Center for Children's Support at the University of Medicine and Dentistry of New Jersey. The ages of the 99 nonoffending mothers ranged from 19 to 52 (M =30.85). The group was comprised of 76 Caucasians, 15 African-Americans, 5 Hispanics, and 3 represented other ethnic groups.

Eighty-four of the participating, nonoffending mothers reported that they believed at least some aspects of their children's sexual abuse allegations, while 15 doubted them. In 36 cases, the perpetrators were the mothers' partners. Of these 36 cases, 17 were separated or divorced from their partners prior to their children's disclosure. An additional 10 separated from their partner following the disclosure. Regarding their own histories, 41 of the mothers reported significant medical histories and 19 acknowledged histories of substance abuse. With regard to their own personal history of contact sexual abuse, 41 of the nonoffending mothers reported a history of contact childhood sexual abuse, 35 reported experiencing physical abuse, 56 of them had been subjected to domestic violence, and 22 had been victims of adult sexual assault.

The ages of the 99 sexually abused children ranged from less than 1-year-old to 14 years (M = 7.17). Seventy-nine were girls and 20 were boys. Ethnicities of the children included 73 Caucasians, 18 African-Americans, 6 Hispanics, and 2 represented other ethnic groups. The alleged perpetrators were identified as fathers or stepfathers in 31 cases, in 53 cases a trusted adult was identified as the perpetrator, and in 15 cases the perpetrator was identified as an older sibling and/or an older peer.

The researchers studied the three groups of nonoffending mothers of sexually abused children and compared them on 17 psychosocial characteristics. The psychosocial characteristics were categorized into 3 variables: background variables, maternal response to allegations, and maternal history of physical and sexual assault. Group comparisons were made on 17 psychosocial characteristics. The assessment process included a structured clinical interview which was a modified version of the Parent Interview that was tested and used by the first author and others in a previous study (McLeer, Deblinger, Atkins, Foa, and Ralphe, 1988).

Data obtained included age of the child; frequency, duration and nature of the abuse; maternal experiences of social support; and maternal history of abuse. The Symptom Checklist-90-Revised (SCL-90-R), developed by Derogatis (1983) was also administered to the mothers. The SCL-90-R is a self-report instrument which measures a broad range of symptom distress, rating the severity from 0 (not at all) to 4 (extremely), and which reflects the Global Severity Index (GSI). Upon administering the standardized measures, the results revealed that symptom distress was reported in all three groups.

These findings also indicated that a mother's personal history of adult sexual assault and perceived aloneness in facing the crisis impacted her response to her child's disclosure of abuse. Twenty-three of the 99 mothers reported feeling alone to a great extent during the investigative period.

Results. Multiple-regression analyses of the psychosocial characteristics on the SCL-90-R's Global Severity Index (GSI) indicated a positive correlation between current symptom distress and a mother's perceived aloneness in facing the crisis. The researchers conducted a series of analyses of variance (ANOVA) to compare the psychosocial characteristics of the three groups. Bonferroni adjustments were applied to guard against chance findings given that 17 different comparisons were being tested. No significant differences were observed between these groups on variables pertaining to the background and allegations of abuse, or reporting the abuse. However they did differ significantly in their report of violence by a partner, with mothers of incest victims reporting a higher prevalence of domestic violence ($p < .001$).

The mothers' sense of aloneness in facing child sexual abuse allegations and their own personal histories of adult sexual assault correlated positively with their GSI scores. While there were no differences between the groups regarding mean levels of symptom distress, the overall level of symptom distress was reported to be comparable to that of female psychiatric outpatients. These findings supported the need for therapeutic intervention for nonoffending mothers of sexually abused children. Group treatment was suggested by the researchers to counteract the feelings of isolation and aloneness and to reduce the overall level of distress.

Parent Support Group

Literature reviewed in this section addressed the significance and impact of caregiver and parental participation in support groups and group therapy on the treatment given to child victims of sexual abuse.

Hyde, Bentovim, and Monck's Study

Hyde, Bentovim, and Monck's study (1995) sought to establish that the addition of group treatment to basic family treatment for sexually abused children would result in an improved outcome for the children and other family members. They defined abuse as "forced stimulation of the abuser's external genitalia by the child, stimulation of the child's external genitalia by the abuser, or mutual masturbation, or fondling of breasts and other parts of the child's body for the sexual satisfaction of the abuser" (p. 1338)

Method. The researchers studied children and their mothers/caregivers referred to a specialist sexual abuse treatment team at the Hospitals for Sick Children at Great Ormond Street in London. Their sample was comprised of 47 sexually abused children from 37 families who were eligible for the treatment study. The mothers of these children were identified as their primary caregivers. Children between the ages of 4 and 16 who were sexually abused more than once in the previous 2 years and who had disclosed the abuse within the previous year were included in the study.

The children and families were randomly assigned to one of two groups: family/network treatment only, or group work in addition to family/network treatment. For the family/network treatment group, therapists met with the children and families regularly at 4 to 6 week intervals. The treatment involved members of the family and a

therapeutic network of community professionals such as social workers and probation officers. Treatment was based on family therapy principles and the initial meetings focused on strengthening the relationship and communication between the current parent figure and the child, depending on whether the child was living at home or in a children's home. Meetings without the children present focused on individual, marital, and family issues which had in some way impacted, triggered or maintained the abusive behavior.

The treatment group which included additional group work received group treatment in addition to the family/network meetings. Groups that were appropriate to each member's age and developmental level were provided. Age-stratified, mixed groups were held weekly for the children between 6 and 10 years of age. Same sex groups were held for three age ranges of abused teenage girls. Separate groups were also held for boys, mothers, adult perpetrators, and caregivers. The duration of the groups varied according to age and need, and ranged from anywhere between 6 and 8 weeks for the younger children, and up to 20 weeks for the older children and adults. In this study, initial research interviews were conducted at the time of the first clinical assessment. The final research interview was conducted at the end of treatment or after 12 months if the treatment was being continued.

All groups used a "goal oriented" approach in that the groups for younger children adopted a self-protection psychoeducational approach. The older children's group, in addition to a psychoeducational approach, focused on a more dynamic understanding and sharing of feelings and mutual peer support. Group goals also focused on reversing the traumatic effects of the abuse; facilitating social development through sharing,

giving and receiving emotional support from peers; and increasing self esteem, assertiveness and the ability to protect oneself. Understanding the nature of the abuse and its effects and developing sexual knowledge were also part of the group goals. Caregiving parents and substitute caregivers explored similar issues in parallel groups. They also addressed issues pertaining to their own response, personal and family issues, the effect of secrecy, and the disclosure of abuse.

Both standardized and clinical measures were used to obtain the data for this study.Data from mothers were collected from self-report measures such as the 28-item "General Health Questionnaire" (GHQ), the Great Ormond Street Self-Image Profile, and 20-item reports of health and behavior for all children. Children between the ages of 8 to 16 were administered the Children's Depression Inventory (CDI), Institute of Child Health Self-Esteem Questionnaire, and 12 items regarding their own health and behavior. Children of ages 6 and 7 were administered the Pictorial Scale of Perceived Competence and Social Acceptance for Children and the Family Relations Test. Data for children under 6 years old were gathered from their parents and from the teachers of all those in school by means of the Teacher Behavior Checklist. Semi-structured interviews with the mothers and their abused children were used to obtain details of the abuse experience, sexualized behavior, the child's peer, social and school adjustment, and their relationships with the caring parent and the perpetrator.

Family members were rated in three main areas: a) taking appropriate responsibility for the abuse; b) the quality of family relationships; and c) dealing with the origins and effects of the abuse. These ratings were given by clinicians at referral and at the 12-month follow-up using 12 family treatment aims (FTAs). FTAs were

rated on 3-point scales (0-nil achieved or minimally; 1-partially achieved, 2-wholly achieved). Separate ratings were made for abused children, nonabusive mothers, and perpetrators. Clinical judgements of "hopeful", "doubtful," and "hopeless" were also made to estimate the capacity for change of individuals and of the overall family system.

The emotional and behavioral state at referral of children over 8 years of age who completed the Children's Depression Inventory (CDI) indicated that 34 % (12/32) scored above the cut-off point indicating a significant level of depressive symptoms. Teacher ratings showed significant behavior disorders in school for 57% of the children (12/21). Mothers/caregivers reported sexualized behavior in 25% (11/43). Mothers entering treatment also appeared to be symptomatic; of 28 women completing the General Health Questionnaire, 24 (86%) had scores over the cut-off point. Families from lower socioeconomic groups were reported to be overrepresented. Nonabusing parents described a poor history of care in their own childhood and 39% (9/23) reported unhappy memories at the start of the interview. Ten mothers (43%) reported experiences of sexual abuse and five (22%) reported experiences of physical abuse in childhood.

The variables studied included the effect of the abuse on the child, the protective capacity of the mother and the quality of her current or former relationship with the child (when they lived together), the degree of responsibility taken by the perpetrator, the origins of abusive behavior, and the nature of family relationships that may have played a part in maintaining the abuse. This study established that while mothers made

more significant progress than their children in the year of treatment, mothers in group work showed better progress than mothers without group work.

Results. A comparison of pre (at the start of treatment) and post (12-month follow-up) treatment measures indicated significant improvement in children's self-reported depression scores ($p < 0.0001$) and in mothers'/caregivers' reports of children's health and behavior ($p < 0.0004$). An item analysis of the CDI indicated a significant improvement on sadness, worry about the future, having very little fun, thinking bad things would happen, thinking bad things were the child's fault, suicidal ideation, anxiety, and ease of decision making. Mothers'/caregivers' reports of the children's symptomatology showed improvement only in temper tantrums, misery, and headaches. The first two of these were the most commonly recorded symptoms at the start of treatment.

Significant improvement was also noted in the mothers'/caregivers' scores who completed the General Health Questionnaire ($p < .001$) and Self-Esteem Questionnaire ($p < .01$). Improvement was found on the GHQ subscores for somatic symptoms, anxiety, and social functioning. Depressive GHQ symptoms (which were less prevalent at the start of treatment) showed improvement in only 50% of the subjects. Overall, 65% of the scores on the GHQ for caregivers were improved and 23% were worse. On the Adult Self-Esteem Questionnaire, 64% had improved scores and 36% were worse.

Results of the clinical measures for the 47 children indicated good improvement in 33 % and moderate improvement in 36%. This was far below the 93% good or moderately good outcome that was predicted at the start of treatment. Little or no improvement was seen in the remaining 31%. A comparison of the initial score

predictions, on the Hopeful, Doubtful, and Hopeless criteria with the final clinical outcome indicated that 52% of children had done as expected, 19% had exceeded clinical predictions and 29% had done worse than expected.

Significant improvement was found in the relationship between mothers and abused children ($p < .0001$), the children's capacity to recognize positive attributes in themselves ($p < .0001$), the children's understanding that the perpetrator was responsible for the abuse ($p < .02$), resolution of conflicted feelings towards the perpetrator ($p < .0001$), and the family's ability to recognize the child's age-appropriate needs ($p < .04$).

This study indicated that as a result of participating in the group program, nonoffending mothers reported lower levels of general distress, less avoidance of abuse related thoughts and feelings, and were able to respond more appropriately to their children's behaviors and other abuse related issues. The researchers noted that when assisted in coping with their own distress, nonoffending mothers appeared to be able to respond better to their children thus enabling them to become a more effective therapeutic resource for their sexually abused children. The parents also appeared to be better able to assist their children in dealing with the abuse related issues by using the behavior management training and education received in the groups.

One of the limitations of this study was that due to both parents and children being in groups at the same time, it was not possible to determine if the improvement reported was solely a function of the group interventions for the nonoffending caregivers/mother. Another limitation was the lack of a control group which the researchers had tried to overcome by utilizing a baseline period. However, since initial

contact may have varied for the group members, it cannot be confidently stated that change was a function of the group treatment only.

Results and generalization about parenting issues should be viewed cautiously as the PPQ was not administered at the time of initial contact. The researchers reported that they were unable to clearly determine if change was due to the cognitive interventions or to the supportive element of the group. The study did not indicate whether these parents continued to receive any professional intervention during the 3-month interim period. The researchers also did not clarify how often and how regularly these groups met. However, they recognized that confounds of maturation, testing, and instrumentation might have affected the results due to repeated administration of these measures in a relatively short span of time.

Winton's study

Winton (1990) evaluated the effectiveness of a support group for parents of sexually abused children and sought to establish the helpfulness of groups for this particular population. This study established that parents found the groups helpful and rated them highly stating that they learned coping skills and felt more confident as parents. Winton hypothesized that group participants would report significant decreases in their children's dysfunctional behavior, they would experience a significant decrease in their stress levels, and they would rate the Parent Support Group as a positive and helpful experience.

Method. Winton (1990) studied 27 parents/caretakers who had participated in the Parent Support Group and completed both pre-group and post-group measures. Demographic data indicated that of the 27 sexual abuse cases, 13 (48%) were

incestuous and 10 (37%) were nonincestuous, and in 4 cases (15%), the perpetrator was not identified. Marital status data indicated that 19 (70%) of the subjects were married, 3 (11%) divorced, and 5 (19%) were either single or unmarried. The participants' ethnic identification revealed that 23 (85%) were Caucasians and 4 (15%) were African-American. Of the participants, 21 (78%) were female and 6 (22%) were male. There were 19 mothers (70 %), 3 fathers (11%), 1 stepmother (4%), 1 stepfather (4%), 1 grandmother (4%) and 2 grandfathers (7%) in this study.

Winton (1990) gave each participant, pre- and post-group, a self-administered evaluation package containing the Louisville Behavior Checklist (Miller, 1984 as cited in Winton, 1990) to measure children's pathological behaviors and the Parenting Stress Index (Abidin, 1983 as cited in Winton, 1990), measuring parents' stress levels in various domains. Participants were also given the Subjective Evaluation Form, a questionnaire designed by the therapists, asking the participants to rate the group therapists and other aspects of the group experience.

Results. The group was comprised of two parts: therapeutic and educational. It was a treatment component in a multidisciplinary, hospital-based child abuse unit. The therapeutic component of the group focused on disclosure, understanding, and dealing with feelings of guilt, anger, fear, and confusion. The educative component focused on three main approaches to parenting, education, and training by utilizing material from the parents' handbooks Systematic Training for Effective Parenting (Dinkemeyer & McKay, 1982; Dinkemeyer, Dinkemeyer, & McKay, 1987 as cited in Winton, 1990) and Parent Effectiveness Training (Gordon, 1975 as cited in Winton, 1990).

Behavioral approaches based on behavior modification techniques of parent training were presented to the parents (Cautela & Cautela, 1983; Patterson, 1975 as cited in Winton, 1990). The inclusion of an educational component was based on the observation that parents of sexually abused children experience difficulty with handling their child's inappropriate behaviors and therefore feel ineffective. According to Winton, some parents appeared to be sabotaging their child's treatment plan, a tactic that seemed to be motivated by parental reluctance to deal with sexual abuse either by denial or by minimizing.

Winton (1990) reported significant decreases in some behaviors as measured by the Louisville Behavior Checklist. Significant decreases were noted in fear ($t = 3.40$, $p < .001$), inhibition ($t = 2.51$, $p < .01$), intellectual deficit/academic disability ($t = 2.71$, $p < 05$), cognitive disability/learning disability ($t = 2.68$, $p < .05$), severity level ($t = 2.59$, $p < .05$), normal irritability ($t = 2.53$, $p < .05$), rare deviance ($t = 2.75$, $p < .05$), neurotic behavior ($t = 2.91$, $p < .01$), psychotic behavior ($t = 2.44$, $p < .05$), and sexual behavior ($t = 2.62$, $p < .01$). A significant decrease was reported in two scales of the Parenting Stress Index: the Child Domain Score and the Adaptability scale ($p < .05$). A majority of the parents rated the group as excellent or good. Participants' responses to the satisfaction questionnaire indicated that they had learned how to cope better after being in the group. The hypothesis that parental stress levels would decrease was not supported by this study. Winton proposed that this could be a result of the brevity of the treatment, which was substantiated by the members' expressed desire to have the groups continue longer than 13 weeks.

Efficacy of Treatment

Several studies addressed the efficacy of various forms of treatment for nonoffending caregivers of sexually bused children. Treatments evaluated included individual therapy, support groups, group therapy and parallel group treatment. This section addresses the impact of support and treatment of non-offending caregivers.

Stauffer and Deblinger's Study

Stauffer and Deblinger (1996) conducted a preliminary outcome study on the effectiveness of concurrent 11-week cognitive behavioral groups for 19 nonoffending mothers and their young, sexually abused children. The efficacy of the program was assessed by measuring change in maternal distress levels and reports of children's behavioral functioning as a function of group participation. Measures of the decrease in the level of maternal distress and maternal reports of children's behavioral functioning were taken at four points: at initial contact (often during the course of the Child Sexual Abuse [CSA] investigation/forensic evaluation), pretreatment (immediately prior to the first group session attended), posttreatment (during the 10th group session) and at a 3-month follow-up (approximately 3 months after the group ended).

The researchers had a three-fold purpose for their intervention: firstly, to assist parents in coping with their own emotional reactions in order to enable them to be more supportive of their children; secondly, to educate parents about ways to initiate and maintain open parent-child communication regarding their children's sexually abusive experiences as well as healthy sexuality issues; and thirdly, to provide parents with behavior management skills to help them handle behavioral difficulties their children may experience as a result of the abuse.

Method. Stauffer and Deblinger (1996) defined nonoffending mothers as biological/adoptive mothers, stepmothers, foster mothers, and other custodial female guardians. Nonoffending fathers who were invited to participate in the group program were excluded from the study due to the small number who attended the group. The site of this study was a center for child support in New Jersey. The center was a joint program of the Department of Pediatrics and Psychiatry at the University of Medicine and Dentistry (UMDN), New Jersey. All families in the group had participated in a CSA investigation conducted by Child Protective Services (CPS). The children included in this study had to have made a disclosure in an individual setting prior to being referred to a group. Both groups (parents and children) met for a total of 11 sessions, each session lasting 2 hours.

Participants for Stauffer and Deblinger's (1996) study were recruited from 6 groups held at the center over a 20-month period with a maximum of 4 subjects from any one group. The sample studied consisted of 19 nonoffending mothers and their children whose ages ranged from 2 to 6 years. The mothers' group was comprised of 14 (74%) biological or adoptive mothers, 3 (16%) foster mothers, 1 (5%) grandmother, and 1 (5%) stepmother. The mothers' ages ranged from 23 to 65 years (M = 34.61, SD = 10.24).

Demographic data indicated that 17 mothers were Caucasians (89%) and 2 (11 %) were African-Americans. With regard to educational background, 8 (42%) had completed high school, 7 (37%) had participated in some postsecondary education, 2 (11%) had completed bachelor's degrees and 1 (5%) had completed a master's degree. Six (32%) of the 19 mothers were married, 2 (11%) were single, 4 (21%) were

separated, 5 (26%) were divorced, and 2 (11%) were widowed. Sixteen (84%) mothers believed all aspects of the allegations and 1 (5%) was uncertain about the veracity of the allegations. Personal histories of violence were reported by 16 (84%) mothers and 3 (16%) reported no history of victimization. Of the 16 who reported histories of violence, 11 (58%) reported violence by a partner, 7 (37%) reported violence by the perpetrator of their child's abuse, 7 (37%) reported adult sexual assault, and 8 (42%) reported child sexual abuse.

The children's group was comprised of 5 (26%) males and 14 (74%) females, of which 16 (84%) were Caucasian and 3 (16%) were African-American. Eight children (42%) were abused by a biological or adoptive parent, 2 (11%) by a step parent, 2 (11%) by another adult relative, 1 (5%) by an adult nonrelative, 1 (5%) by an older sibling, 2 (11%) by older peers, and 3 (16%) by similar-aged peers.

The structured interview (a multiple choice-response questionnaire) used in this study was a modified and abbreviated version of the parent interview tested and used by the researchers in a previous study (Stauffer & Deblinger, 1993). Other assessment instruments used were: the Child Behavior Checklist (CBCL), the Child Sexual Behavior Inventory (CSBI), the Symptom Checklist-90-Revised (SCL-90-R), the Impact of Events Scale (IES), and the Parent Practices Questionnaire (PPQ).

The structured interview provided the demographic characteristics of the parent and child, abuse characteristics, the context and nature of the child's disclosure, parental reactions to the allegations, and the mother's history of victimization. The CBCL was administered to evaluate the impact of the parents' and children's groups on the children's emotional and behavioral difficulties. A T score of 70 or above is considered

to be in the clinical range.

The CSBI was administered to evaluate the impact of the parents' and children's groups on the children's sexualized behaviors. The SCL-90-R was administered to evaluate the impact of the nonoffending parents' group on mothers' self-reported levels of general distress. The IES was administered to evaluate the impact of the parents' group, especially the cognitive coping and gradual exposure modules, on mothers' self-reported levels of distress related to their children's sexual abuse. Parental self-reports and behavioral reports of preschoolers were utilized as data due to the lack of standardized instruments for preschoolers.

Results. The interventions used in both groups were based on cognitive behavioral techniques that have been previously used and evaluated in individual treatment with this population (Deblinger, McLeer, & Henry, 1990). Data were collected over a 2-year period during which time six groups were completed. From a total of 34 nonoffending mothers who participated in the group at one time or another, only 19 mothers completed the group program.

Treatment consisted of three modules. The first focused on education/coping. Three sessions were conducted in which cognitive reframing was modeled to help parents cope with the abuse of their child. The second module was six sessions in length and focused on behavior management skills which addressed behavioral principles to improve the understanding and management of their children's behavior. The third module consisted of two sessions that focused on communication, modeling, and gradual exposure to CSA education and experiences to help parents initiate and maintain open communication with their children.

The main objectives of the children's group were to reduce feelings of stigmatization and isolation, improve the children's overall sense of well-being, enhance their communication and coping skills regarding their abuse (first two sessions), and to provide developmentally appropriate information about CSA and body safety skills. The children's group also used cognitive behavioral techniques such as modeling and role plays to help children develop skills for using time-outs to manage their own behavior.

Results of assessment at initial contact (baseline), pre- and postgroup, and after a 3-month follow-up indicated that cognitive behavioral group interventions were effective in decreasing symptomatology in both children and their nonoffending parents and that this decrease was maintained for a 3-month period. A series of one-way repeated measures of analysis of variance (ANOVA) was used to examine changes in the dependent variables as a function of evaluation time. A significant change over time was observed in the SCL-90-R GSI, (F (3, 51) = 4.53, $p < .05$); IES avoidance, (F (3, 54) = 5.33, $p < .05$); PPQ Total, (F (2, 32,) = 11.47, $p < .01$); and CSBI Total, (F (3, 54) = 12.85, $p < .01$). A priori post-hoc analyses using correlated t tests and the Bonferroni adjustment were conducted to compare significant changes in the pre- and posttest measures as compared to the baseline period. Results indicated no significant changes from the baseline period to pretreatment. Significant improvement was observed in the pre- and posttreatment scores of the SCL-90-R GSI, ($t(17) = 3.49$, $p < .01$); IES avoidance, ($t(18) = 2.72$, $p < .05$); PPQ Total, ($t(16) = -5.29$, $p < .01$); and CSBI Total, ($t(18) = 4.68$, $p < .01$). Satisfaction questionnaires completed by parents indicated that the group helped them to feel more confident in their ability to manage their children's

difficulties (94.7%).

Though the instruments used in this study were helpful in assessing outcome, it must be remembered that the responses to these questionnaires are contingent upon the parents' self-reports. Also, how the participants experienced the role of Child Protective Services and/or the role of the police (e.g., as an intrusion) could have impacted their responses.

Grosz, Kempe, and Kelly's Study

In their pilot study of Extrafamilial Sexual Abuse (ESA) in children under the age of 10 years, Grosz, Kempe, and Kelly (2000) showed that children's treatment groups and parent support groups were necessary for a good prognosis in child abuse treatment outcome. This pilot study was conducted at a university medical facility located off campus in an outpatient child abuse center. Priority was given to children under the age of 7, due to the dearth of services provided to this population. Families participated in crisis counseling, individual treatment for the child victim and/or parent, children's treatment groups, and parent support groups.

The goal of this study was to decrease the emotional distress of child victims and impacted families of ESA. Another goal of this study was to pilot the use of group treatment for those under 10 years of age. A treatment plan was presented to the family with recommendations for the child victim, parents, and siblings. At least one parent was required to participate in a parent support group when their children participated in a children's treatment group. Several parents participated in the parent support group when their child was not appropriate for the children's treatment group. Simultaneous children's and parents' groups met weekly for 1.5 hours. The average length of

participation in group treatment was from 6 to 9 months, and the range of participation was 1 session to 15 months. The schedule for groups generally followed the school year calendar with new groups initiated in the fall because attendance often diminished during the summer months. Parent support groups followed an open-ended format, and attendance usually included 3 to 8 participants per group session. New families benefited greatly from the support of families who had already made progress in recovery. Experienced families could better appreciate their own progress when they were able to extend support to families in the initial crisis stages just after disclosure.

Grosz et al., (2000) noted that the parents were initially emotionally immobilized and many had reported feeling helpless. Parents also reported feeling like a failure as parents because they had not been able to protect their child from the sexual abuse. This was intensified when the sexual abuse occurred over a period of time and when their child was unable to disclose directly to them. Many families had functioned well until this crisis but found the disclosure of sexual abuse overwhelming. Their trust in the safety of their family, friends, and community was shattered. Some were blamed by others for not preventing the abuse. Some were criticized for voicing allegations against perpetrators who appeared to be good citizens or neighbors. Parents needed a supportive adult to talk with since it was important that they not express the full extent of their anger or sadness with their children. Others have also recommended this form of treatment (Davies, 1995; Deblinger & Heflin, 1996; Regehr, 1990).

Method. A sample of 246 children between the ages of 2 and 14 who reported incidents of ESA, and 323 parents who participated in the program were evaluated in the Recovery for Children and Parents (ReCAP) program from 1984 through 1991. The

child sample included 103 (42%) boys and 143 (58%) girls from 219 families. Of the 323 parents, there were 206 biological mothers, 3 grandmothers, 2 adoptive mothers, 1 step-mother, 108 biological fathers, 11 step-fathers, 1 adoptive father, and 1 grandfather.

There were multiple child victims in 24 families (2 victims in 20 families and 3 victims in 4 families). Evaluation indicated that no sexual abuse had occurred in 7 cases (2.8%) of this sample of 246 children. In 6 additional cases (2.4%) evaluation yielded inconclusive findings, and it was undetermined whether sexual abuse had occurred. As a result, the number of children in the final sample was 233. Seventy-one children (43%) participated in the children's treatment group and 104 parents (32%) of the sample of 323 parents participated in the parent support group. Evaluation consisted of assessment of marital discord, previous physical or sexual abuse to any family member, financial and health stressors, and the family's capacity to use therapy. This assessment was done primarily by self-report. The formal evaluation was completed after three sessions of individual and family interviews, usually over the course of several weeks.

Results. The parent support group provided an effective and appropriate resource for parents to address their own distress and to increase their support for the child victims. Themes included responding to child victims and siblings, understanding the parent's own feelings of distress, interacting with the legal systems, and dealing with friends, relatives, school personnel, and neighbors about the sexual abuse. The therapists monitored the families' needs for more individualized intervention. The therapists for the parent support group provided information about the major themes of the children's treatment group and solicited information about the children's behavior at

home and at school. This information was shared with the children's therapists at weekly staff meetings to coordinate the treatment of both child victims and parents. It was considered important to help parents understand that the recovery of their family could go forward whether or not criminal prosecution was possible or successful. Parents felt powerless and revictimized by the criminal justice system when they were not informed of decisions, when there were delays, or when their case could not be prosecuted. As cases were prosecuted, the parent support group offered increased support when the process was slow, when there were continuances, and when repeated preparation for court appearances was needed. The parent support group also helped families whose cases could not be prosecuted to refocus on the priority of recovery for family members.

Decreases in behavioral symptoms, based on clinical observations and parent reports, were the major indicator that children had improved sufficiently to graduate from treatment. A follow-up survey indicated that support from the mother and the father were important recovery factors for child victims. This survey also indicated that group treatment for the child victim was a contributory recovery factor.

Grosz et al., (2000) reported that significant indicators of recovery for parents were decreases in anxiety, anger, sadness, and guilt feit about the sexual abuse. Parents also demonstrated a renewed confidence in their parenting ability as well as improvement in their self-image and marital relationship. The follow-up survey of recovery factors for parents indicated that 50% attributed recovery to "group treatment for parents." The researchers postulated that group treatment was found to be effective for children due to its supportive effect and that a certain amount of relief was obtained

in knowing that others had experienced similar issues. Symptoms of sleep disturbance were reported to have improved significantly by 75%; regressive behavior symptoms were reported to have improved by 58%, dependent and clinging behavior by 56%; and fearing threats from abuser and guilt-participation in abuse was reported to have improved by 54%. Most mothers (81%) also reported that they did not observe their children hurting themselves.

A major limitation of the Grosz et al., (2000) study was the lack of operational definitions. The researchers failed to identify what they were measuring and how they planned to do so. Another major limitation of this study was the absence of any standardized measures to assess the impact of participation and treatment of mothers and their children. This was also evident in the absence of pre- and posttest standardized measures, which are more available today.

Nelki and Watters Study

Nelki and Watters (1989) investigated the effectiveness of a parallel group model of treatment that incorporated both sexually abused children and their caregivers in treatment. The children and caregivers met on a weekly basis in separate groups. After 9 weeks of a combination of educational and psychodynamic approaches (teaching children about dealing with sexual abuse and psychodynamic play therapy), the researchers reported significant reduction in problem behaviors in the children as reported by the caregivers.

Method. The children's group initially consisted of 7 girls between the ages of 4 and 8 who were referred from the Child Sexual Abuse Workshop at the Tavistock

Clinic, London. All the children had disclosed their abuse, and the time elapsed between disclosure and the first group meeting varied between 3 and 15 months.

Suitability as group candidates was assessed by the therapists who met with the referred candidates and their caregivers 6 to 8 weeks prior to the group's commencement. At the end of the study, one child was withdrawn by her mother. Of the 6 girls, 4 were reportedly living with the mothers' and cohabitees at the time of abuse, and 2 lived with their mothers alone. One mother was hospitalized with a psychotic illness following disclosure and the child was placed in foster care. The perpetrator was clearly identified in five cases; each was a male related to or known by the child. Of the five identified perpetrators, one was a natural father, one an uncle, one a cousin, one a cohabitee, and one a babysitter. In the sixth case the natural father was suspected. The interval between the abusive incident and disclosure ranged from 1 month to 1 year.

The parallel parent group consisted of 5 natural mothers and 1 foster mother who were seen together and informed of the main themes and specific topics to be covered each week. Pre- and postgroup questionnaires consisting of 33 problems drawn from recognized symptoms following sexual abuse were administered to the caregivers who were asked to rate whether the problem was absent (0), minor (1), or major (2). The first review of their children's behavior took place 8 weeks after the group ended. Data were obtained from clinical observations.

Results. Pre- and postgroup questionnaires were compared. A paired t test on the pre- and postgroup differences reported a value of $t = 3.051$ ($p = 0.025$). Results indicated a significant reduction on the total scores derived from reported problems

before and after group treatment. However, Nelki & Watters (1989) reported that certain problems were noted more frequently at posttest, such as being clingy, increased sexual play, and increased reference to sexual subjects. Postgroup questionnaires indicated that five children were reported as showing increased confidence. At 1-year follow-up no incidents of reabuse were reported. Two children were recommended for individual therapy, 1 child was referred for family therapy, and 2 were referred for social work support.

One major limitation of the study was that maturational effects could not be ruled out. There appeared to be a long lapse between the time of disclosure and the commencement of treatment for some of the children. Another limitation of the study was that the time lapse varied across children. There also seemed to be no indicator regarding the relational quality between the mothers and their children, and therefore factors contributing to success could not be clearly predicted. Other limitations were the small sample size and the lack of a control group.

DelPo and Koontz's Study

DelPo and Koontz (1991) conducted a reality-based ego-supportive group therapy study with mothers of children who were sexually abused by a father, stepfather, or a man in the paternal role. The group met weekly for 2 years at a comprehensive community mental health center. This group was formed at the request of some mothers of children who were incest victims. Members were referred to the group by therapists at the mental health center, by child protective service workers of the Department of Social Services (DSS), or they were mandated to attend by the family court.

Method. Seventeen women participated in this study, with 7 being active members when the group ended. The age of the mothers ranged from early 20s to late 30s, except for 1 woman who was in her early 50s. With regard to ethnicity, 8 were Caucasian, 8 were African-American, and 1 was Hispanic. The socioeconomic level of the mothers ranged from lower class to middle class. Each of the mothers in this study reported a history of physical, emotional, and/or sexual abuse as a child and/or adult. Eight of the women had less than a high school education and 4 worked in jobs requiring post-high school education. Thirteen women were either unemployed or worked part-time or full-time at low paying, unskilled jobs

Results. This unstructured, open-ended group met for 1½ hour sessions during which the group members discussed personal, interpersonal, and family issues. The purpose of the mothers' group was to facilitate more autonomous functioning in the women and to help them become more effective in protecting their children. The goal of the leaders of the group was to provide interpersonal experiences that would enhance the mothers'self- esteem and encourage more autonomous adult functioning. The goals of the mothers were to make connections with mothers of other incest victims, to reduce their feelings of isolation and shame, and to receive support from others who had been in similar situations. Anxiety and/or depression, disturbances in eating, sleeping, and activity patterns, and vague physical complaints were identified as pre-group symptomatology. The effectiveness of this group was assessed by means of self-report by the participants who stated that interactions with other group members, within and outside the group sessions, decreased their sense of isolation, aloneness, and stigma.

Limitations of this study were the lack of standardized measures to accurately reflect the levels of stress being experienced and the lack of a control group. The subjects' self-reported improvement needs to be viewed and accepted cautiously as some of the participants may have attended the group under coercion and this could bias the sample studied.

Deblinger, Steer, and Lippmann's Study

The study conducted by Deblinger, Steer, and Lippmann (1999) sought to determine whether the pre- to post-test therapeutic gains that had been found in a previous study for an initial sample of 100 sexually abused children suffering from posttraumatic stress disorder (PTSD) symptoms would be sustained 2 years after treatment. The children had been suffering from depression which was manifested in reexperiencing phenomena, avoidance behavior, and arousal symptoms. The children and their nonoffending mothers were randomly assigned to one of four cognitive-behavioral treatment conditions: child only, mother only, child and mother, or a community comparison condition. They were followed for 3 months, 6 months, 1 year, and 2 years after treatment.

Deblinger et al.'s (1999) study indicated that pre- to posttreatment improvement held across the 2-year follow-up period. This was evidenced by the significant decrease in the three measures of psychopathology used in the preliminary study (i.e. externalizing behavior problems, depression and PTSD symptoms). Deblinger et al., (1996) proposed that cognitive behavioral approaches could be successful in treating school-aged children when the nonoffending parent, usually the mother, was included in the process.

Method. The sample consisted of 100 sexually abused children whose ages ranged from 7 to 13 years old (mean age = 9.89 years) and their parents. Eighty-three percent were girls and 17 % were boys. With regard to the ethnicity of the sample, 70% were Caucasian, 21% were African-American, 7% were Hispanic, and 2% were "Other." A biological father or stepfather was identified as the perpetrator by 31 % of the children, and penile penetration was involved in 35% of the cases. Duration of the abuse was reported to be 7 months or more in 53 % of the cases and less than 7 months in 43% of the cases.

Assessment instruments used in this study consisted of a structured background interview, the Children's Depression Inventory (CDI), the Child Behavior Checklist (CBCL), a slightly modified version of the Parenting Practices Questionnaire (PPQ), and a self-report measure completed by parents that assessed the quality of parental interactions with the children. A posttraumatic stress disorder (PTSD) index which consisted of the PTSD section of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E) was also administered to evaluate the children's PTSD symptoms related to the sexual abuse.

The children and their nonoffending mothers were randomly assigned to one of three experimental cognitive-behavioral interventions or to a community comparison condition. Twenty-five children were assigned to a cognitive behavioral treatment condition that involved the child only. The role of the nonoffending mothers in this group was limited to informal feedback they received from the therapist. Twenty-five children were assigned to a cognitive-behavioral intervention that required the participation of the nonoffending mother who learned to serve as the child's therapeutic

agent. The children in this group did not meet directly with the therapist. Twenty-five children were assigned, along with their mothers, to a cognitive behavioral approach that involved the participation of both mother and child. Joint parent and child work in the latter stages of therapy was a hallmark of this group. Twenty-five children and nonoffending mothers were referred to therapists in their own communities for treatment (community comparison condition).

Results. A series of repeated multivariate analyses of covariance (MANCOVA) controlling for pretest scores indicated that the three measures of psychopathology (externalizing behavior problems, depression, and PTSD symptoms) that had significantly decreased in the original study were comparable to the posttest scores at the 3-month, 6-month, 1-year, and 2-year time periods. Only 12 out of the 25 completed pretest CBCL surveys were available at posttest. The data examined were only from those participants who had completed pre/posttest and follow-up assessments. Significant therapeutic gains had been reported in the previous study across the four follow-up periods. Improvement, as measured by the PPQ, was significant beyond the .01 level. Subsequent profile analyses indicated that the posttest and 3-month gains in the effectiveness of parenting practices were comparable, but dropped slightly after a year ($p < .01$). Deblinger et al., (1999) also reported that the 1- and 2-year adjusted mean PPQ scores were comparable. This study indicated no return to previous symptomatology over a 2-year period of time. The researchers used this information to reiterate the significance of group therapy for nonoffending caregivers (Deblinger & Heflin, 1996).

Limitations of this study included missing data and other confounding variables such as remuneration paid for attendance at the follow-up study. Another possible confound was the lack of information regarding any other form of intervention in which the child or nonoffending parent might have been concurrently engaged. Since most of the data obtained were contingent on self-report, rater bias must also be taken into consideration.

Cohen and Mannarino's Study

Cohen and Mannarino (1996), in their initial study with sexually abused preschool children, reported the efficacy of a specific cognitive-behavioral treatment model for preschool children and their parents. In this study, treatment outcome for sexually abused preschoolers and their parents was assessed. The researchers postulated that Cognitive-Behavioral Therapy Adapted for Sexually Abused Preschool-Aged children (CBT-SAP) would be more effective than Nondirective Supportive Therapy (NST) in decreasing emotional and behavioral symptoms in sexually abused preschool children.

Method. Sexual abuse was defined as sexual exploitation involving physical contact between a child and another person. "Exploitation" implied an inequality in power between the child and the abuser on the basis of age, physical size, and/or the nature of the emotional relationship. If the perpetrator was a child, he or she had to be at least 5 years older than the abused child. "Physical contact" included anal, genital, oral, and/or breast contact.

To be included in this study, children had to have experienced some form of sexual abuse as defined above, with the most recent episode occurring not more than 6 months prior to referral to the study. Eighty-six subjects were recruited for the study, 6

of which dropped out after completing one or two treatment sessions (early dropouts) and 7 dropped out after completing three to eight sessions (late dropouts). In addition, 6 subjects were removed from the study before completing treatment because of their persistent sexually inappropriate behavior with others. Thus, a total of 67 subjects completed the treatment and were included in the data analysis.

According to Cohen and Mannarino (1996), the noncompleters did not differ from each other with regard to demographics or initial symptomatology. No significant differences were found between noncompleters and completers, except that the noncompleters were of a lower socioeconomic status (SES) than the completers (Hollingshead V vs. IV, $F = 2.16$, $p = .049$). There were no significant differences noticed between the CBT-SAF and NST groups in the treatment completers or on any demographic or abuse-specific variables. The mean age of treatment completers was 4.68 years (range 2.11 to 7.1 years); 58% were female and 42% were male. Males did not differ from females with regard to age, placement, race, or SES. They also did not differ with regard to number of times abused, use of force, or identity of perpetrator. Racial composition was 54% Caucasian, 42% African-American, and 4% other.

Seventy-five percent of the subjects lived with one or both biological parents, 3% lived with adoptive parents, 4% lived with grandparents, 3% lived with other relatives, 13% lived with a long-term foster parent, and 2% lived with another caretaker. Data on the severity of sexual abuse indicated that 25% were abused once, 26% were abused 2 to 5 times, 15% were abused 6 to 10 times, 29% were abused more than 10 times, and, in 5% of the cases, the number of abuse episodes was not known. The identity of the perpetrators was reported as the biological father (15%), the biological mother (2%), the

mother's paramour (10%), the uncle (7%), the babysitter (7%), the older child/adolescent (13%), and multiple abusers or other (46%). The type of abuse experienced was reported as genital fondling only (46%), vaginal and/or anal intercourse (26%), oral-genital contact (22%), fondling of breasts (3%), and other or unknown (3%). More than one type of abuse was experienced by 34% of the subjects.

One outcome measure administered directly to children was the Preschool Symptom Self-report (PRESS), a pictorial instrument designed to facilitate the self-report of affective symptoms by preschool children. Parents were administered the Child Behavior Checklist (CBCL), the Child Sexual Behavior Inventory (CSBI) and a nonstandardized Weekly Behavior Record (WBR). These outcome measures were administered pre- and post-treatment.

Results. Sixty-seven subjects were randomly assigned to either Cognitive-Behavioral Therapy Adapted for Sexually Abused Preschool Aged children (CBT-SAP) or Nondirective Supportive Therapy (NST). Treatment consisted of 12 individual sessions for both the child and the parent. Two-tailed t-tests were used to compare CBT-SAP and NST scores on the CBCL, CSBI, and the WBR. There appeared to be no significant differences across all subjects on all pre-treatment measures. However, posttreatment measures indicated significant differences between groups, with the CBT-SAP group being less symptomatic on the CSBI, the WBR Total Behavior score, and 2 of the 4 broad band CBCL scales: Total Behavior Problems scale ($F = 5.55$, $p = .020$) and internalizing scales ($F = 3.23$, $p = .075$). The PRESS did not indicate any significant between group differences. Results indicated that CBT-SAP

was more effective than NST at decreasing symptomatology on all the outcome measures used.

One of the limitations of the study was that Cohen and Mannarino (1996) did not indicate what criteria were used to establish the two groups (CBT-SAP and NST) and how group assignment was randomized. Another limitation was that the self-reports may not have been a pure measure of the efficacy of treatment. The effect of treatment provided to the mother may have been a confounding variable by providing her with a better understanding of the dynamics of sexual abuse, and thereby may have increased her understanding and awareness of the abuse. The researchers did not make it clear as to who was included in the category "preschoolers." It was also not clear whether the children included in this study had prior treatment in any setting.

Deblinger, McLeer, and Henry's Study

In another study, Deblinger, McLeer, and Henry (1990) examined the effectiveness of a cognitive behavioral program for 19 sexually abused children suffering from PTSD. The factors that influenced the subjects' responsiveness to treatment were also examined. Variables studied included age, time lapsed since the last abusive episode, relationship to the abuser, and duration and nature of the abuse. Nineteen girls (aged 3 to 16 years) who had reported contact sexual abuse and who met the criteria for PTSD were included in the study. The sample was administered tests on three occasions: at the initial evaluation, 2 to 3 weeks prior to the commencement of treatment, and following 12 treatment sessions. Contact sexual abuse was defined as "sexual touching, with or without force, by anyone at least 5 years older than the child" (p. 748).

Method. Nineteen females between the ages of 3 and 16 years (mean age = 7.79 years) who were evaluated and treated at the Child Sexual Abuse Diagnostic and Treatment Center at the Medical College of Pennsylvania were included in the study. Among those studied, 68.4% suffered the most severe form of sexual abuse involving genital-oral contact and/or penile penetration of the vagina or anus; 26.3% suffered direct genital touching and/or digital penetration of the vagina or anus; the remaining 5.3% experienced inappropriate sexual touching and/or sexualized kissing with clothes on. The majority of perpetrators were fathers or stepfathers (52.6%); 21.1% were other male relatives; 21.1 % were trusted male adults (nonrelatives); and one child (5.3%) was abused by a male stranger.

Structured interviews were conducted with the nonoffending primary caretaker and the child to assess the presence or absence of PTSD symptoms before, during, and after treatment. At the initial evaluation parents completed the Child Behavior Checklist (CBCL), and children who were at least 6 years old were administered the Children's Depression Inventory (CDI) and the Spielberger State-Trait Anxiety Inventory (STAIC) again approximately 2 to 3 weeks prior to the initiation of treatment.

Results. All children and their caregivers participated in 12 individual structured treatment sessions. The child intervention consisted of several cognitive behavioral methods such as gradual exposure, modeling, education, coping and prevention skills training. The parent sessions consisted of modeling, exposure, prevention training and behavior management skills.

Deblinger et al., (1990) reported no significant difference in the baseline PTSD data collected at two points (initial evaluation and 2 to 3 weeks prior to

commencement of treatment). However, the results after 12 weeks of treatment indicated significant improvement on all measures. Paired t-tests comparing pre- and postassessments of PTSD symptoms for all 19 subjects revealed significant improvement across the PTSD subcategories, including reexperiencing phenomena ($p < 0.000$), avoidance behavior ($p < 0.000$) and arousal symptoms ($p < 0.000$). The researchers reported that although treatment did not appear to eliminate all PTSD symptoms, there were no children who continued to meet the full diagnostic criteria for PTSD following treatment.

Paired t-tests comparing Baseline 1 (initial evaluation) and Baseline 2 (prior to the commencement of treatment) on the CDI, CBCL, and the STAIC revealed no significant changes over the baseline period. The researchers reported significant changes in the paired t-test analyses, which compared all 19 subjects' Baseline 2 scores on the CBCL with their scores following 12 structured treatment sessions. Significant improvement was noted on the externalizing subscale of the CBCL ($p < 0.004$) as well as the internalizing subscale ($p < 0.000$). The researchers also reported significant differences in the children's self-report depression scores ($p < 0.05$), state anxiety scores ($p < 0.001$) and trait anxiety scores ($p < 0.05$) following the 12 treatment sessions.

A major limitation of this study was the lack of a control group. The effects of parental involvement were not clearly delineated even though it appeared that Deblinger et al., (1990) attributed the posttreatment assessment as being indicative of this effect. Maturational effects could not be ruled out in this study.

Review of this study showed that teaching behavior management concepts and applying them to behaviors resulting from sexual abuse has helped parents increase

their awareness of normal sexual behavior exhibited by their children and that this could be a direct or indirect result of intervention.

Conclusion

The overall significance of treatment offered to nonoffending caregivers will be summarized in this section. The methodological limitations of the studies reviewed will be discussed and suggestions for future research will also be addressed.

Methodological Limitations

Given the nature of the topic under scrutiny and the severity of its long-term and short-term implications, most of the studies did not include random sampling. Depending on the research design, this omission could have resulted in questionable validity for some studies. In some studies, standardized measures were not used and some researchers developed their own measures. The use of non-standardized measures affected the reliability and validity of those studies. Lack of standardization leads to another difficulty: that of consistency in the definition of terms used and measured. This lack resulted in doubtful construct validity. External and internal intervening variables in some studies also made the attribution of causality almost impossible to determine.

There were many problems associated with sampling, particularly as this issue seems to have been avoided in some studies. Most of the samples were from hospitals or other sites where a more random level of sampling might have been possible. Many of the researchers did not address interrater reliability nor did they address issues related to the utilization of nonrandom samples. The distress level of families referred or

seeking professional help could have impacted the outcome of some studies. Families often experience high levels of stress following the disclosure of sexual abuse and this might have affected how the children were rated by their parents on behavioral scales.

A potential limit to the external validity of the studies reviewed was that they were conducted in specialized, intensive sexual abuse treatment centers as opposed to clinics or programs that may have lacked the funding and/or the support for highly abuse-specific treatment approaches. Results of studies done in well funded programs do not necessarily generalize to all treatment programs. Using hospital-based or site-specific samples in research on sexually abused children and their nonoffending caregivers also impedes generalization to all abused children as the results gleaned are from those attending therapy and not from those living in the community. Inadequate sample size was a major methodological concern faced by most of the empirical research. Several studies examined limited samples which led to obtaining fewer than 50 subjects. The small sample size affected statistical power to determine group differences as well as decreased the external validity of any results.

Other concerns included biased sampling and the questionable reliability of self-report instruments which were used extensively in these empirical studies. Self-reports of sexual abuse are vulnerable to bias due to the subjects' emotions associated with the event and their level of comfort in discussing sexual matters. Similarly, parental reports of children's behavior and adjustment are also prone to subjectivity. When interpreting results, researchers need to take into consideration not only the personality characteristics of the sexually abused child, but also those of the nonoffending caregiver. Most of these studies did not have a control group of untreated

subjects, which resulted in a lack of control for maturational effects.

The inconsistency of definitions, or lack of definitions, were other limitations found in the articles reviewed. Empirical research tends to have many diverse definitions for childhood sexual abuse. Most researchers used the following standard definition of sexual abuse used in the Child Abuse and Neglect Reporting Act "Sexual assault on, or the sexual exploitation of, a minor....It also includes lewd or lascivious conduct with a child under the age of 14 years...Sexual exploitation includes conduct or activities related to pornography depicting minors and promoting prostitution by minors" (Child Abuse Prevention Handbook, p.12). Some literature limited sexual abuse to sexual contact (ranging from touching through intercourse) between a child and an individual at least 5 years older, ignoring other abuse such as pornography. Another limitation of the studies reviewed was that the emotional development level of the children and its implications for treatment were not addressed.

Future Research

Future research should focus on difficulties in determining treatment efficacy. These difficulties could be a result of a multitude of intervening variables such as the relationship between the perpetrator and the nonoffending parent, the relationship between the abuse survivor and the perpetrator, the age of the victim, when the abuse occurred, and the personality characteristics of the abused survivor. Research should also focus more on the marital or relational aspects of the nonoffending caregivers of sexually abused children, given that the mother is often implicated in the incest triangle. The efficacy of parallel group treatment needs to be further investigated addressing issues pertaining to the limitations of research in this area. In order to specify effects of

treatment, future research should include both normal, nonabused controls as well as a control group of psychologically disturbed children (e.g., physically abused children) in order to identify effective treatments. Attention must be paid to the size of the sample being studied in order to increase the applicability of the study. Community based research will also help alleviate the challenges researchers are faced with when trying to include ethnic minorities. More recent outcome measures like the Trauma Symptom Checklist for Children should be utilized to enable the comparison of findings across studies. Another means of establishing the most effective treatment modalities for sexually abused children and their nonoffending caregivers is to try different types of treatment to determine the most effective modality. These results might be further enhanced if the children's groups were studied concurrently with their parents' groups. Finally, strategies need to be developed to include fathers or boyfriends as empirical evidence suggests that, although some fathers did attend the programs, they were generally underrepresented.

Summary

This review has evaluated the efficacy of group treatment for the nonoffending caregivers of children who have been sexually abused. The overall results of the literature reviewed suggest that parallel group treatment or concurrent treatment of the sexually abused child/children and their nonoffending caregivers has proven to be most effective. Concurrent parent groups with an emphasis on psycho-education and providing support for the family impacted by the abuse and/or the involvement of the legal system, have been most helpful in alleviating parental stress and helping parents perceive otherwise "abnormal" behavior as being "normal."

Nonoffending caregivers should be encouraged to view sexual abuse as a family problem in which all members are affected as this will help provide support from the parents and siblings of the abused child. The nonabused children in the family will also have an opportunity to explore and express how the abuse has impacted them. One common finding in almost all the articles was the nonoffending caregivers'/mothers' own personal history of sexual abuse. This reality must also be taken into account when treating sexually abused children. Programs treating sexually abused children will benefit if their treatment included and provided needed services to the nonoffending parents and/or caregivers of these children and other family members.

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